Autism Program: 877-563-9347 Fax: 816-237-2372

Authorization Request for Applied Behavioral Analysis for Autism Spectrum Disorder

This form should be completed by the Board Certified Behavior Analyst (BCBA) or approved provider who will be rendering and/or supervising the services. Please complete all parts as clearly and as specifically as possible. Illegibility may result in a delay in the authorization. Omissions and generalities could result in a peer review or denial due to lack of information.

This form should be completed, reviewed with parent(s), and submitted to VIVA Health 10 business days prior to the end of the current authorization for ongoing care requests.

Identifying Data

Member's Name	Member's ID#
Date of Birth	Age
Current Diagnosis Code(s)	Current Authorization Number

Parent/Guardian Name(s)	Contact Number(s)
Parent/Guardian Email Address	

Provider Information

BCBA/AS Name		Provider NPI
Group Name		Group Tax ID Number
Address		
Phone	Fax	Email
Line Therapists Involved in Treatment		

Requested Date to Begin Treatment	
BCBA/AS Signature	Date
Parent/Guardian has reviewed and agrees with the Treatment Plan Parent/Guardian Signature	Date Reviewed with Parent
*MD/PhD Name	MD/PhD Phone
*MD/PhD has reviewed and agrees with the Treatment Plan *MD/PhD Signature	Date Reviewed with MD/PhD

**Benefits and requirements may vary by individual state mandates for these services.*
VIVA Health may verify parent or MD/PhD signature and date of treatment plan review at any time.

Treatment Request

Indicate the type of Treatment Services being provided

☐ Comprehensive	☐ Focused
Rationale for Services for requested authorization period:	

Member and Parent Schedules

Write member and/or parent therapy/training times in the first column, CPT Codes to be billed in the second, and the setting in the third. Multiple codes may be listed per line.

Monday	CPT Code	Choose Setting
Tuesday	**CPT Code**	**Setting**
Wednesday	**CPT Code**	**Setting**
Thursday	**CPT Code**	**Setting**
Friday	**CPT Code**	**Setting**
Saturday	**CPT Code**	**Setting**
Sunday	**CPT Code**	**Setting**

Total Hours Requested per Week

Please add up the treatment hours for each CPT code and list them in the designated spaces.

Member Service Codes	0359T*____	0360T & 0361T ____	0364T & 0365T ____	
	*untimed single unit	0366T & 0367T ____		
	0368T & 0369T (Treatment by Protocol Modification) ____(Parent Training)			
Family & Group Codes	0370T ____	0371T ____	0372T _____	
Exposure Codes	0362T & 0363T ____		0373T _____	0374T ____

Member Update

Psychosocial Information *include diagnostic history, primary support/social history, and family history of ASD and related disorders, history of current and past behavioral functioning, summary of caregiver interview*

Education *include grade, current and previous schools attended, dates and locations, special education or services provided*

Does the member have an IEP?	If yes, please include a copy

Current Medications *include psychotropic, over-the-counter, vitamins, and herbal remedies*

Medical History *include major illness or injuries, hospitalizations, surgeries, diagnoses related to ASD (FragileX, etc.) and allergies*

Any additional relevant information *includes information such as identified barriers to progress, scheduling, or special circumstances.*

Current Assessments

Vineland Adaptive Behavior Scale Scores		Date Completed		
Composite	**Communication**	**Daily Living Skills**	**Socialization**	**Motor Skills**
Compared to previous Adaptive Behavior Composite Score				
☐ Improved Standard Deviation	☐Same Standard Deviation	☐Drop in Standard Deviation		

Assessment Name:			Date Completed	
Initial Score ____		Previous Score ____	Current Score ____	
☐ New Assessment	☐ Significant Change	☐ Moderate	☐ Minimal Change	☐ No Change
☐ Assessment Write-Up and/or Graph Included				

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Instructions for Completing each Goal Section

Please provide an update on the goals from the last treatment request and additional goals to be completed in the next six-month authorization.

1. Date Goal Began: Use the calendar to select the date the goal was added to the treatment plan. This should be the start date of the **ORIGINAL** goal even if revisions to goal are made over time.
2. Goal Status: Use the dropdown menu to select the current goal status. Please be sure to include goals addressed during the previous six month authorization and mark as appropriate.
3. Baseline and Present Level of Performance: Please describe the specific behaviors observed for present level of performance. If goal is continued, please include initial baseline. Please include corresponding dates for information.
4. Specific Goals: Define the goals directly related to increasing or decreasing the behavior targeted in the baseline. Use specific client centered, measurable goals. Describe how the goal will be measured and mastery criteria.
5. Goal Notes: Additional relevant information.
    a. For continued goals, indicate changes in goal or how barrier(s) are/have been addressed.
    b. For discontinued goals, indicate the reason and termination date
    c. For mastered goals, indicate date mastered

Goals

Does the member have a behavior plan? ☐Yes ☐No	If yes, please attach.

Summary of hours spent by type of goal. Please include approximate number of hours and number of goals from each area.				
Adaptive: **# of goals:** **Hours per week:**	**Behavior:** **# of goals:** **Hours per week:**	**Communication:** **# of goals:** **Hours per week:**	**Social Skills:** **# of goals:** **Hours per week:**	**Other:** **# of goals:** **Hours per week:**

Date Goal Began	**Goal Status**	**Date Goal Mastered**
Number of hours per week estimated to achieve goal:		
If goal was continued, indicate current percentage of progress toward completion:		
Baseline and Present Level of Performance with Corresponding Dates		
Measurable Goal with specific mastery criteria **Goal Notes**		

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Parent/Guardian Involvement and Goals

Summary of participation and additional resources accessed over last authorization period				
Parent Training Hours Scheduled weekly/ monthly:				☐ Does not participate
Parents Generalize Skills in Natural Environment (Indicate % of goals family is able to implement)	☐80-100%	☐ 51-79%	☐ 21-50%	☐ Less than 20%
Family able to implement behavior plan or interventions (% of accuracy of implementation)	☐80-100%	☐ 51-79%	☐ 21-50%	☐ Less than 20%
☐ I attest that parent participated in at least 80% of scheduled parent training.				
☐ I attest that parent training was offered and parent did not or refused to participate.				

Parents Demonstrate Understanding of the Following ABA Principles				
Principle	Mastered	Progressing	Targeted	Not Yet Addressed
Reinforcement				
Differential Reinforcement				
Motivational Operations				
Prompting				
Fading				
Shaping				
Antecedents				
Consequences				
Data Collection				
Collecting ABC Data				
Identifying Functions				
Extinction				
Task Analysis				
Chaining				
Other:				
Other:				
Other:				
Other:				

Please summarize goals to be targeted during treatment period.

Please summarize progress on goals from the last six months.

Coordination of Care

Please check the providers that you have had coordination of care with during the past six month authorization. In the provided box, please write a summary of the information relevant to treatment gathered through coordination of care with each of the providers.

School	Speech Therapist	Primary Care Physician
Psychologist	Occupational Therapist	Mental Health Therapist
Psychiatrist	Physical Therapist	Other Relevant Providers
Please enter summary of relevant information from coordination of care:		

Community Integration and Aftercare Plan

Please describe the transition and aftercare plans. Please include the information as outlined. Anticipated Outcome of Treatment to include the following:

- description of the anticipated overall expectation of member's functional performance as a result of treatment.
- description of the core deficits of autism that will be targeted for improvement through treatment to improve member's overall functioning level.

Transition plan to include the following information:

- specific skills to address with both the family and member and how they are actively being addressed to promote readiness to move to a lower level of care
- detailed strategy for moving to lower level of care detailing how hours will be faded connected to measurable objectives for family and member
- community resources identified to support the family
- community resources to support member's ability to generalize skills to various environments and provide support as needed

Aftercare plan to include the following information:

- Resources needed and/or identified
- Reasons for contact after discharge
- Supports in place to encourage successful discharge
- How services would resume, if needed

Estimated End Date to Meet Goal Outcomes for Treatment:

- Complete for all treatment requests beyond the first six months
- ND understands that the estimated end date may change based on the member's progress in treatment

Outcome Goals of Treatment
Transition Plan
Aftercare Plan

Estimated End Date to Meet Goal Outcomes for Treatment:
☐ I attest that the ND ABA Treatment Request Form including projected treatment outcomes, transition plan, and aftercare plan was discussed with parent.